

# ATTACHMENT 14

## Prior Authorization Request Form (PA/RF) completion instructions for physician services

(For prior authorization requests submitted after HIPAA implementation)

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information will include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. The Prior Authorization Request Form (PA/RF) is used by Wisconsin Medicaid and is mandatory when requesting PA. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Providers may submit PA requests, along with all applicable service-specific attachments, including the Prior Authorization/Physician Attachment (PA/PA) or Prior Authorization/“J” Code Attachment (PA/JCA) by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may submit PA requests with attachments to:

Wisconsin Medicaid  
Prior Authorization  
Ste 88  
6406 Bridge Rd  
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the submitted claim(s).

### SECTION I — PROVIDER INFORMATION

#### Element 1 — Name and Address — Billing Provider

Enter the name and complete address (street, city, state, and Zip code) of the billing provider. The name listed in this element must correspond with the Medicaid provider number listed in Element 4. *No other information should be entered in this element, since it also serves as a return mailing label.*

#### Element 2 — Telephone Number — Billing Provider

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

#### Element 3 — Processing Type

Enter processing type “117” (physician services, including family planning clinics, rural health clinics, and federally qualified health centers). The processing type is a three-digit code used to identify a category of service requested.

#### **Element 4 — Billing Provider's Medicaid Provider Number**

Enter the eight-digit Medicaid provider number of the billing provider. The provider number in this element must match the provider name listed in Element 1.

### **SECTION II — RECIPIENT INFORMATION**

#### **Element 5 — Recipient Medicaid ID Number**

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the recipient's Medicaid identification card or the Eligibility Verification System (EVS) to obtain the correct identification number.

#### **Element 6 — Date of Birth — Recipient**

Enter the recipient's date of birth in MM/DD/YY format (e.g., September 8, 1996, would be 09/08/96).

#### **Element 7 — Address — Recipient**

Enter the complete address of the recipient's place of residence, including the street, city, state, and Zip code. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

#### **Element 8 — Name — Recipient**

Enter the recipient's last name, followed by his or her first name and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

#### **Element 9 — Sex — Recipient**

Enter an "X" in the appropriate box to specify male or female.

### **SECTION III — DIAGNOSIS / TREATMENT INFORMATION**

#### **Element 10 — Diagnosis — Primary Code and Description**

Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

#### **Element 11 — Start Date — SOI (not required)**

#### **Element 12 — First Date of Treatment — SOI (not required)**

#### **Element 13 — Diagnosis — Secondary Code and Description**

Enter the appropriate secondary ICD-9-CM diagnosis code and description relevant to the service/procedure requested, if applicable.

#### **Element 14 — Requested Start Date**

Enter the requested start date for service(s) in MM/DD/YY format, if a specific start date is requested.

#### **Element 15 — Performing Provider Number**

Enter the eight-digit Medicaid provider number of the provider who will be providing the service, *only* if this number is different from the billing provider number listed in Element 4.

#### **Element 16 — Procedure Code**

Enter the appropriate procedure code for each service/procedure/item requested.

**Element 17 — Modifiers**

Enter up to four modifier(s) corresponding to the procedure code listed if a modifier is required by Wisconsin Medicaid.

**Element 18 — POS**

Enter the appropriate place of service (POS) code designating where the requested service/procedure/item would be provided/performed/dispensed. Refer to Attachment 5 for a list of allowable POS codes for physician services.

**Element 19 — Description of Service**

Enter a written description corresponding to the appropriate procedure code for each service/procedure/item requested.

**Element 20 — QR**

Enter the appropriate quantity (e.g., number of services, days' supply) requested for the procedure code listed.

**Element 21 — Charge**

Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

*Note:* The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to *Terms of Provider Reimbursement* issued by the Department of Health and Family Services.

**Element 22 — Total Charges**

Enter the anticipated total charge for this request.

**Element 23 — Signature — Requesting Provider**

The original signature of the provider requesting/performing/dispensing this service/procedure/item must appear in this element.

**Element 24 — Date Signed**

Enter the month, day, and year the PA/RF was signed (in MM/DD/YY format).

*Do not enter any information below the signature of the requesting provider — this space is reserved for Wisconsin Medicaid consultants and analysts.*